Part 7: Monitoring and Continuation of Waiver Services

Sections 7.1 – 7.9

Section 7.1: Level of Care Re-Evaluation

The process for re-evaluation of level of care is the same as the initial evaluation, but it is performed by the contracting waiver case management entity as opposed to a contractor or BDDS staff.
Developmental Disabilities, Autism, and Support Services Waiver program participants must be re-evaluated each year to meet ICF/MR level of care (Individuals on the Autism Waiver must also have a diagnosis within the Autism Spectrum).

The DDRS Central Office completes the annual level of care re-evaluations for these waivers for children who have not reached their 6th birthday. For children age 6 and older and for all adults, the annual level of care re-evaluations are completed by the contracting case manager who must be a Qualified Mental Retardation Professional (QMRP).

Section 7.2: Medicaid Eligibility Re-Determination

The Division of Family Resources (DFR) is the group that determines eligibility for all Indiana Social Services Programs. The DFR will assist you in determining which programs are right for you and your family. You can learn more about the application process by going to Apply for Medicaid at http://member.indianamedicaid.com/apply-for-medicaid.aspx .

Each year, the local DFR determines the individual's continuing eligibility to receive Medicaid.

Section 7.3: Annual Plan of Care/Cost Comparison Budget (CCB) Development

All individuals/participant (also known as the consumer) receiving Waiver services must have a new Plan of Care/Cost Comparison Budget (CCB) approved on an annual basis and the Person Centered Service Planner must also be updated at least annually. The Annual CCB represents the service plan identified for the individual during the required review of the individualized support plan. **Annual CCBs are to start the date following the expiration of the previous CCB and cover a 12 month period.**

In the event that an Annual CCB is not submitted or cannot be approved in a timely manner, the most recently approved CCB is automatically converted to a new annual CCB. The total cost/amount of services on the "auto-converted", or" default", CCB is determined by the cost of services and supports appearing on the most recently approved but expiring CCB. The auto-converted, or default CCB ensures that there is no loss of services. The case manager is subsequently contacted and required to complete the annual planning process and ISP and CCB revision.

The plan is developed by the Individualized Support Team (IST) identified by the participant. The participant has the right and power to command the entire process. The case manager, participant and others of the participant's choosing form the IST. The CCB is developed a minimum of six weeks prior to the initial start date of services or six weeks prior to the end date of the current annual service plan. The CCB is routinely developed to cover a timeframe of 12 consecutive months.

The Cost Comparison Budget is driven by a person-centered planning process, coordinated in conjunction with the participant, his or her guardian or legal representative, and members of the individual's support team. Case Managers are responsible for the facilitation and development of the participant's Person-Centered Description (PCD), a document divided in to five key components:

1. Personal Priorities, which includes the Personal Priority Statements and Personal Priority Narratives;
2. Relationships;
3. Communication;
4. Initiatives, or Outcomes; and
5. Historical Narrative.

The PCD to be updated at least annually, and is to ascertain the individual's needs, wants, and desires using person-centered planning philosophy processes. It is the Case Manager's responsibility to ensure the person-centered planning process accounts for and documents the participant's preferences, desires, and needs, including his or her likes and dislikes, means of learning, decision-making processes, and desire to be productive. An individual's PCD should be reflective of his or her long-term hopes and desires so as to develop an Individual Support Plan (ISP) that encourages and supports the achievement of these goals. Each participant's PCD will be reviewed and updated every 90 days as part of the individual's Annual Planning Quarterly Update team meetings. All contracting case managers are to be trained in person-centered thinking and be PCD/ISP certified.

The health and safety indicator is an assessment conducted by the case manager that helps identify the health and safety needs of an individual. The assessment is a tool used to help identify risks related to health, behavior, safety and support needs for waiver participants.

The participant is informed of available waiver services at the time of application, during enrollment and development of the PCP/ISP and CCB and on an ongoing basis throughout the year as needed. The participant's Case Manager is knowledgeable in all services available on the waiver and is responsible for providing the participant with information about each covered service, its definition, scope and limitations.

The Plan of Care/Cost Comparison Budget (CCB) is developed based upon the outcomes of the initial, annual or subsequent meeting of the Individualized Support Team during which the Person-Centered Plan and the Individualized Support Plan are developed. This entire process is

driven by the participant and is designed to recognize the participant's needs and desires. The Case Manager holds a series of structured conversations, beginning with the participant/ guardian and with other individuals, identified by the participant that know them well and can provide pertinent information about them, to gather initial information to support the person-centered planning process. The overall emphasis of the conversations will be to derive what is important to and what is important for the participant, with a goal of presenting a good balance of the two. The case manager facilitates the IST meeting, reviews the participant's desired outcomes, their health and safety needs and their preferences, and reviews covered services, other sources of services and support (paid and unpaid) and the budget development process using the objective based allocation for waiver services. The case manager then finalizes the ISP and completes the CCB.

Coordination of waiver services and other services is completed by the Case Manager. Within 30 days of implementation of the plan, the Case Manager is responsible for ensuring that all identified services and supports have been implemented as identified in the Individualized Support Plan and the CCB. The Case Manager is responsible for monitoring and coordinating services on an ongoing basis and is required to record a weekly case note for each participant. A formal 90 day review is also completed by the case manager with the participant and includes the IST. Each waiver provider is required to submit a monthly or quarterly report summarizing the level of support provided to the participant based upon the identified supports and services in the Individualized Support Plan and the Cost Comparison Budget. The Case Manager reviews these reports for consistency with the ISP and CCB and works with providers as needed to address findings from this review.

The ISP identifies the services needed by the participant to pursue their desired outcomes and to address their health and safety needs. Each outcome within the ISP has associated initiatives designed to address potential barriers or maintenance needs in relation to the desired outcomes and the support and services needed to facilitate the outcomes. The initiative also identifies all paid and unpaid responsible parties and, includes the name of the provider agency, the service, and the staffing position(s) within the agency that are responsible for the initiative. The participant may be the responsible party for an initiative if they so determine. In addition, each initiative has a specific timeframe identified, including a minimum review timeframe for each initiative.

The Plan of Care/Cost Comparison Budget (CCB) identifies the name of the waiver service, the name of the participant-chosen provider of that service, the cost of the service per unit, the number of units of service and the start and end dates for each waiver service identified on the CCB.

The ISP and CCB are reviewed a minimum of every 90 days and updated a minimum of every 365 days. The participant can request a change to the CCB at any point, be it a new service provider, or a change in the type or amount of service. If a change to the ISP and/or the CCB is determined necessary during that time, the participant and/or family or legal representative

and IST will meet to discuss the change. The actual updating of the CCB is completed by the Case Manager based upon the participant and the IST discussion and determination.

Section 7.4: Plan of Care/Cost Comparison Budget (CCB) Updates and Revisions

The ISP and CCB are reviewed a minimum of every 90 days and updated a minimum of every 365 days. The participant can request a change to the CCB at any point, be it a new service provider, or a change in the type or amount of service. If a change to the ISP and/or the CCB is determined necessary during that time, the participant and/or family or legal representative and IST will meet to discuss the change. The actual updating of the CCB is completed by the Case Manager based upon the participant and the IST discussion and determination.

Section 7.5: State Authorization of the Annual/Update Cost Comparison Budget

The Case Manager will transmit the Plan of Care/Cost Comparison Budget (CCB) electronically to the State's Waiver Specialist who will review the CCB and Person Centered Service Planner and confirm the following:

- The individual is a current Medicaid recipient within one of the following categories:
    - Aged **(MA A)**
    - Blind **(MA B)**
    - Low Income Families **(MA C)**
    - Disabled **(MA D)**
    - Disabled Worker **(MA DW)**
    - Children receiving Adoption Assistance or Children receiving Federal Foster Care Payments under Title IV E - Sec. 1902(a)(10)(A)(i)(I) of the Act **(MA 4 & MA 8)**
    - Children receiving adoption assistance under a state adoption agreement - Sec 1902(a)(10)(A)(ii)(VIII) **(MA 8)**
    - Independent Foster Care Adolescents – Sec 1902(a)(10)(A)(ii)(XVII) **(MA 14)**
    - Children Under Age 1 – Sec 1902(a)(10)(A)(i)(IV) **(MA Y)**
    - Children Age 1-5 - Sec 1902(a)(10)(A)(i)(VI) **(MA Z)**
    - Children Age 1 through 18 - Sec 1902(a)(10)(A)(i)(VII) **(MA 9 & MA 2)**
    - Transitional Medical Assistance – Sec 1925 of the Act **(MA F)**
    - Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121 **(MA U)**

- The individual has a current ICF/MR level of care approval and for participants of the Autism Waiver, a formal diagnosis of Autism for the Autism Waiver

- The individual's indentified needs will be met and health and safety will be assured;

- The costs are consistent with identified needs of the individual and the services to be provided;
- That if the total cost of Medicaid waiver and regular Medicaid State plan services for the individual exceeds the total costs of serving an individual with similar needs in an ICF/MR facility, the programmatic cost-effectiveness will be maintained;
- The individual/participant or guardian has signed, indicating acceptance of, the CCB; signed that he/she has been offered choice of certified waiver service providers; and signed that he/she has chosen waiver services over services in an institution.

The Waiver Specialist may request additional information from the Case Manager to assist in reviewing the packet.

If the Waiver Specialist denies the CCB, a denial letter must be transmitted to the Case Manager, BDDS (for Initials and Annuals only) and Service Providers. Within three (3) calendar days of receipt of the denial the Case Manager must complete and provide a copy of a Notice of Action (HCBS Form 5), the Appeal Rights as an HCBS Waiver Services Recipient, and an explanation of the decision to deny to the individual/guardian.

If the Waiver Specialist approves the CCB, the approval letter and Notice of Action are transmitted to the Case Manager, BDDS (for Initials and Annuals only) and Service Providers. The Case Manager notifies the individual or guardian within three (3) calendar days of receipt of the approval and provides a copy of the approval letter.

Section 7.6: Service Plan implementation and Monitoring

Case Managers are responsible for the implementation and monitoring of the service plan (inclusive of the Individualized Support Plan, Cost Comparison Budget and, often, other non-funded services) and participant health and welfare.

A minimum of one face-to-face contact between the case manager and the participant is required every 90 days, and as frequently as needed to support the participant. In each meeting, the participant's support team will review current concerns, progress and implementation of the plan of care.

A 90 Day Checklist is utilized by the Case Manager and Individualized Support Team in order to systematically review the status of the Cost Comparison Budget, the Individualized Support Plan, any behavioral support program, choice and rights, medical needs, medications, including psychotropic medications (if applicable), seizure management (if applicable), nutritional/dining needs, incident review, staffing issues, fiscal issues, and any other issues which may be identified in regard to the satisfaction and health and welfare of the participant. The checklist is also used to verify that emergency contact information is in place in the home, including the

telephone numbers for Adult Protective Services or Child Protective Services and the Bureau of Quality Improvement Services. Case
Managers educate the participant by offering examples of when the emergency contact numbers should be called.

The case manager is required to enter a weekly case note indicating the progress and implementation of the service plan. The case manager also maintains regular contact with the participant, family/guardian and the provider(s) of services through home and community visits or by phone to coordinate care, monitor progress and address any immediate needs. During each of these contacts the case manager assesses the service plan implementation as well as monitors the participant's needs.

The monitoring and follow up method used by the case manager include conversations with the participant, the parent/guardian, and providers to monitor the frequency and effectiveness of the services through monthly team meetings and regular face-to-face and phone contacts. The case manager asks:

- Are the services being rendered in accordance with the plan of care?
- Are the service needs of the participant being met?
- Do participants exercise freedom of choice of providers?
- What is the effectiveness of the crisis and back up plans?
- Is the participant’s health and welfare being ensured?
- Do participants have access to non-waiver services identified in the plan of care including access to health services?

The implementation and effectiveness of the plan of care is reviewed in quarterly IST meetings. A monitoring report has been developed by the contractor of case management services and is sent to the DDRS Case Management Liaison, DDRS management staff and to the Office of Medicaid Policy and Planning (OMPP) on a quarterly basis for review. The report includes confirmation of annual review (PCP/ISP/LOC), noting month and date.

At all times, full, immediate and unrestricted access to the individual data is available to the State, including the DDRS Case Management Liaison position as well as other members of the DDRS Executive Management Team and OMPP.

Service Problems:
Problems regarding services provided to participants are targeted for follow up and remediation by the case management provider in the following manner:

- Case Managers conduct a face-to-face visit with each participant no less frequently than every 90 days, and complete a 90 Day Review Checklist at that time.

- They investigate the quality of participant services, and indicate on the checklist if any problems related to participant services are not in place.
- For each identified problem, they identify the timeframe and person responsible for corrective action, communicate this information to the interdisciplinary team, and monitor to ensure that corrective action takes place by the designated deadline.
- Case Manager Supervisors and District Directors within the case management organization monitor each problem quarterly via the State Hot List system to ensure that case managers are following up on, and closing out, any pending corrective actions for identified problems.

At least every 90 days, in conjunction with the 90 Day Review Checklist, Case Managers update the participant's Individualized Support Plan (ISP) progress notes, to indicate if all providers and other team members are current and accurate in their implementation of plan activities on behalf of the participant.
Any lack of compliance on the part of provider entities or other team members is noted within the participant's Participant Outcome Measurement Tool (COMT), and communicated to the noncompliant entity for resolution. Case Manager Supervisors and District Directors monitor this tool on no less than a monthly basis to ensure follow up and completion of all identified outcomes for each participant.

Section 7.7: Interruption/Termination of Waiver Services

An individual's waiver services will be terminated when the individual:

- Voluntarily withdrawals;
- Chooses institutional placement/entering Medicaid-funded long-term care facility;
- Dies;
- Needs services so substantial that the total cost of Medicaid services for the individual would jeopardize the Waiver program's cost effectiveness;
- No longer meets ICF/MR level of care criteria;
- Is no longer eligible for Medicaid services
- No longer requires Home and Community-Based Services; or
- Is no longer developmentally disabled

Other examples of circumstances appropriate for interruption/termination may include a participant being arrested, in jail, awaiting trial, convicted/sentenced.

When an individual terminates Waiver services, the Case Manager must complete an electronic "termination" Data Entry Worksheet (DEW), enter the information in the Insite database, and electronically transmit the information to the DDRS database. The DEW is also automatically transmitted to OMPP to enter the Waiver termination information in the Indiana AIM database.

Completion of the termination DEW also results in an auto-generated Notice of Action. Within three (3) calendar days of the termination, the Case Manager must, provide the individual or guardian with a copy of the Notice of Action form, the *Appeal Rights as an HCBS Waiver Services Recipient* instructions, and an explanation of the termination. As appropriate, other service options are to be discussed with the individual and guardian.

Section 7.8: Waiver Slot Retention After Termination and Re-Entry

The following situations related to waiver slot retention after Termination are contingent upon review and approval by the State.

Upon review and approval of the State, if an individual who has been terminated from the Waiver wishes to return to the program, he or she may do so within the same Waiver year of his or her termination, if otherwise eligible. The individual shall return to the Waiver without going on a waiting list. "Within the same Waiver year" is considered as follows:

- Autism Waiver: January 1 through December 31
- Developmental Disabilities Waiver: October 1 through September 30
- Support Services Waiver: April 1 through March 31

An individual who has been terminated from the Waiver program within 30 calendar days may resume the Waiver with the same level of care approval date and Cost Comparison Budget (CCB) and Service Planner if the individual's condition has not significantly changed and the CCB and Service Planner continue to meet his or her needs.

- The Case Manager must certify that the individual continues to meet level of care criteria
- The Case Manager must complete a "Resumption" Data Entry Worksheet, enter it in the Insite database, and submit it electronically to the DDRS database. The information will be automatically transmitted to the OMPP to enter into the Indiana AIM database.

If an individual who has been terminated from the Waiver program longer than 30 calendar days and wishes to return to the program and is otherwise eligible,

- The Case Manager is responsible for developing the level of care packet and CCB and Person Centered Service Planner following the same processes described in the "Annual Level of Care Determination: and the "Initial CCB" sections.

- The Case Manager is to indicate a "Re-Entry" CCB and Service Planner when electronically transmitting them to the State Waiver Specialist via the INsite database.

- When the individual "Re-Enters" Waiver services, the Case Manager must enter a Confirmation of Waiver Start form in the INsite database and electronically transmits it to the DDRS database. The information will be automatically transmitted to the Office of Medicaid Policy and Planning (OMPP) to enter in the Indiana AIM database.

- When the Confirmation of Waiver Start form is received electronically by DDRS, it is reviewed and once accepted, an approval letter will be automatically transmitted back to the Case Manager.

- Within three (3) days of receiving the Re-Entry CCB approval letter, the Case Manager must print a Notice of Action (HCBS Form 5) and sign it. The Case Manager must provide copies of the Notice of Action form and Addendum (containing information from the CCB and Person Centered Service Planner) to the individual/guardian and to all of the individual's waiver service providers.

When an individual "re-enters" Waiver services:

- If within 30 days of terminating Waiver services, the annual level of care and CCB dates remain the same dates as they were prior to the termination of Waiver services,

- If more than 30 days since terminating Waiver services, the new level of care and CCB dates are used for determining when future annual level of care determinations and CCBs are due.

If an individual participant interrupts or terminates waiver services within 30 days of the end of the waiver year with the intention of returning to waiver services early in the next waiver year, the anticipated return to the waiver must occur within 60 days of the next waiver year or the individual may be permanently removed from services.

Section 7.9: Parent/Guardian Providing Paid Services

Without exception, relatives* are not permitted to provide services to a related* waiver participant under Adult Foster Care.

Without exception, legal guardians of children under 18 may not receive payment for any waiver service.

However, a relative* (excluding a spouse) may sometimes provide other waiver service(s) rendered to **adult** waiver participants when that relative* is employed by or a contractor of a Division of Disability and Rehabilitative Services (DDRS)-approved provider.

All of the following must be met before a relative* may be considered to be a provider:

- The individual receiving services is at least 18 years of age;

- The relative* is employed by or a contractor of an agency that is approved by DDRS to provide care under the waiver;
- The relative* meets the appropriate provider standards (per 460 IAC 6) for the service(s) being provided;
- The decision for the relative* to provide services to an **adult** waiver participant is part of the Person Centered Planning process, which indicates that the relative* is the best choice of persons to provide services from the DDRS-approved provider agency, and this decision is recorded and explained in the Individualized Support Plan (ISP);
- There is detailed justification as to why the relative* is providing service;
- The decision for a relative* to provide service(s) is evaluated periodically (i.e. at least annually) to determine if it continues to be in the best interest of the individual;
- Payment is made only to the DDRS-approved provider agency in return for specific services rendered; and
- The services must be rendered one-on-one with the participant or in shared settings with group sizes allowable per specified waiver service definitions and documented as acceptable by all relevant individualized support teams. Authorization for shared or group services must be reflected on and documented via the approved Notice of Action for each group participant. With the exception of groups of waiver participants as noted above, the relative* may not be responsible for others (including their other children or family members) nor engaged in other activities while providing services.

*** Related/relative implies any of the following natural, adoptive and/or step relationships, whether by blood or by marriage, inclusive of half and/or in-law status:**

1) Aunt (natural, step, adopted)
2) Brother (natural, step, half, adopted, in-law)
3) Child (natural, step, adopted)
4) First cousin (natural, step, adopted)
5) Grandchild (natural, step, adopted)
6) Grandparent (natural, step, adopted)
7) Parent (natural, step, adopted, in-law)
8) Sister (natural, step, half, adopted, in-law)
9) Spouse (husband or wife)
10) Uncle (natural, step, adopted)

NOTE: As explained under Section 10.24 of this manual, Residential Habilitation and Support services (RHS) reimbursable waiver funded services furnished to an adult waiver participant by any combination of relative(s)* and/or legal guardian(s) may <u>not</u> exceed a total of 40 hours per week.